

**TEXAS STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
REQUEST FOR AFFILIATION AGREEMENT**

DATE:

It is requested that approval be given for obtaining an affiliation agreement with <<Facility Name>> for the purpose of placing a student in an internship/residency/clinical practice.

It is desired that students be placed in this agency under the agreement beginning <<Date>>.

Contact Person:

Name

Title

Street

City/State/Zip

Email

Send Via: Email or Mail
Circle One

Justification:

Clinical Education Approved: _____ Date _____
Placement
Coordinator/Field Disapproved: _____ Date _____
Placement Coordinator:

Dept/Program Approved: _____ Date _____
Chair:
Disapproved: _____ Date _____